FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024463

Facility Name: PETERSON PARK HEALTH CARE CENTER

Address: 6141 N. Pulaski (Number) Chicago (City) 60646 (Zip Code)

County: Cook

Telephone Number: (773) 478-2000 **Fax #** (773) 478-8408

IDPA ID Number: 36-2999153-001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	LELAND J. COHN
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,808	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,259		2,377	6,636	8
9	SNF/PED					9
10	ICF	41,236	4,747	562	46,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,495	4,747	2,939	53,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.29%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/78

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 2,300

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTI # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	253,068	27,591	20,901	301,560		301,560		301,560			1
2	Food Purchase		306,356		306,356	(36,893)	269,463	(272)	269,191			2
3	Housekeeping	91,934	30,074		122,008		122,008		122,008			3
4	Laundry	73,695	7,039		80,734		80,734		80,734			4
5	Heat and Other Utilities			144,834	144,834		144,834	3,421	148,255			5
6	Maintenance	53,258		63,958	117,216		117,216	1,847	119,063			6
7	Other (specify):*											7
8	**TOTAL General Services**	471,955	371,060	229,693	1,072,708	(36,893)	1,035,815	4,996	1,040,811			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,994,481	88,059	28,178	2,110,718		2,110,718	(12,739)	2,097,979			10
10a	Therapy		3,095	12,605	15,700		15,700		15,700			10a
11	Activities	163,128	18,688	6,039	187,855		187,855		187,855			11
12	Social Services	220,427		8,460	228,887		228,887		228,887			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,378,036	109,842	70,882	2,558,760		2,558,760	(12,739)	2,546,021			16
	C. General Administration											
17	Administrative	126,046		375,514	501,560		501,560	(221,960)	279,600			17
18	Directors Fees											18
19	Professional Services			117,866	117,866	(4,980)	112,886	(3,423)	109,463			19
20	Dues, Fees, Subscriptions & Promotions			73,245	73,245		73,245	(38,902)	34,343			20
21	Clerical & General Office Expenses	67,102	33,968	186,817	287,887		287,887	73,803	361,690			21
22	Employee Benefits & Payroll Taxes			450,230	450,230	36,893	487,123	27,435	514,558			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,670	6,670		6,670		6,670			24
25	Other Admin. Staff Transportation							10,715	10,715			25
26	Insurance-Prop.Liab.Malpractice			77,810	77,810		77,810	3,828	81,638			26
27	Other (specify):*							4,614	4,614			27
28	**TOTAL General Administration**	193,148	33,968	1,288,152	1,515,268	31,913	1,547,181	(143,890)	1,403,291			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,043,139	514,870	1,588,727	5,146,736	(4,980)	5,141,756	(151,633)	4,990,123			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

PETERSON PARK HEALTH CARE CENTER
0024463
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	36,893	
2	FOOD		36,893

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	4,980	
19	PROFESSIONAL FEES		4,980

To reclass cost of appealing real estate taxes

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER #0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			171,642	171,642		171,642	18,349	189,991			30
31	Amortization of Pre-Op. & Org.			4,665	4,665		4,665		4,665			31
32	Interest			126,439	126,439		126,439	3,869	130,308			32
33	Real Estate Taxes			205,523	205,523	4,980	210,503	8,571	219,074			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			781	781		781	5,779	6,560			35
36	Other (specify):*											36
37	**TOTAL Ownership**			509,050	509,050	4,980	514,030	36,568	550,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,764	79,864	151,628		151,628		151,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,212	103,212		103,212		103,212			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		71,764	183,076	254,840		254,840		254,840			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,043,139	586,634	2,280,853	5,910,626		5,910,626	(115,065)	5,795,561			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,199	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(424)	21		18
19	Entertainment	(37,402)	20		19
20	Contributions	(968)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,564)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,116)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(436)	20		28
29	Other-Attach Schedule	(41,248)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (161,231)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	46,166		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 46,166		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,065)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
PETERSON PARK HEALTH CARE CENTER
ID# 0024463
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 197	6	1
2	Veterans Expense	(12,739)	10	2
3	Marketing	(15,000)	19	3
4	Trust Fees	(600)	20	4
5	Theft Loss	(90)	21	5
6	Other Holiday Gifts	(4,075)	22	6
7	Adjust to allowable legal fees	(8,941)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(41,248)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(272)											(272)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			3,421									3,421	5
6	Maintenance	197		1,650									1,847	6
7	Other (specify):*													7
8	**TOTAL General Services**	(75)		5,071									4,996	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,739)											(12,739)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(12,739)											(12,739)	16
	C. General Administration													
17	Administrative			(286,324)	64,364								(221,960)	17
18	Directors Fees													18
19	Professional Services	(23,941)		20,518									(3,423)	19
20	Fees, Subscriptions & Promotions	(39,406)		504									(38,902)	20
21	Clerical & General Office Expenses	(83,194)		156,997									73,803	21
22	Employee Benefits & Payroll Taxes	(4,075)		31,510									27,435	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			10,715									10,715	25
26	Insurance-Prop.Liab.Malpractice			3,828									3,828	26
27	Other (specify):*				4,614								4,614	27
28	**TOTAL General Administration**	(150,616)		(62,252)	68,978								(143,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(163,430)		(57,181)	68,978								(151,633)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	2,199		16,150									18,349	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			3,869									3,869	32
33	Real Estate Taxes			8,571									8,571	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			5,779									5,779	35
36	Other (specify):*													36
37	**TOTAL Ownership**	2,199		34,369									36,568	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(161,231)		(22,812)	68,978								(115,065)	45

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				SHABAT & ASSOC.	SKOKIE	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	FUTURE ASSOCIATES	100.00%	$ 3,421	$ 3,421	15
16	V	6	MAINTENANCE		FUTURE ASSOCIATES	100.00%	1,650	1,650	16
17	V	19	PROFESSIONAL FEES		FUTURE ASSOCIATES	100.00%	20,518	20,518	17
18	V	20	LICENSES, DUES, FEES		FUTURE ASSOCIATES	100.00%	504	504	18
19	V	21	CLERICAL & GENERAL		FUTURE ASSOCIATES	100.00%	135,513	135,513	19
20	V	22	EMPLOYEE BENEFITS		FUTURE ASSOCIATES	100.00%	29,803	29,803	20
21	V	25	AUTO EXPENSE		FUTURE ASSOCIATES	100.00%	10,715	10,715	21
22	V	26	INSURANCE		FUTURE ASSOCIATES	100.00%	3,828	3,828	22
23	V	30	DEPRECIATION		FUTURE ASSOCIATES	100.00%	16,150	16,150	23
24	V	32	INTEREST		FUTURE ASSOCIATES	100.00%	3,869	3,869	24
25	V	33	REAL ESTATE TAX		FUTURE ASSOCIATES	100.00%	8,571	8,571	25
26	V	35	EQUIPMENT RENTAL		FUTURE ASSOCIATES	100.00%	5,779	5,779	26
27	V	17	ADMINISTRATIVE		FUTURE ASSOCIATES	100.00%	89,190	89,190	27
28	V	21	CLERICAL & GENERAL		FUTURE ASSOCIATES	100.00%	21,484	21,484	28
29	V	22	EMPLOYEE BENEFITS		FUTURE ASSOCIATES	100.00%	1,707	1,707	29
30	V								30
31	V	17	MANAGEMENT FEES	375,514	FUTURE ASSOCIATES	100.00%		(375,514)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 375,514			$ 352,702	$ * (22,812)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	72,000	Shabat & Associates		136,364	$ 64,364	15
16	V	27	Payroll Taxes		Shabat & Associates		4,614	4,614	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 140,978	$ * 68,978	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CEN] # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Shabat	Director	Administrative	39.00%	See Attached	30	54.55%	Salary	$ 40,125	17-1	1
2								Allocated	136,364	17-7	2
3											3
4	Nachshon Draiman	Director	Administrative	32.06%							4
5											5
6	Haim Perlstein	Director	Administrative			4	6.67%	Allocated	17,190	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 193,679		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FUTURE ASSOCIATES
Street Address: 7514 N SKOKIE BLVD.
City / State / Zip Code: SKOKIE IL 60077
Phone Number: (847) 982-1195
Fax Number: (847) 982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Management Fees	925,144	4	8,428		375,514	3,421	1
2	6	MAINTENANCE	Management Fees	925,144	4	4,064		375,514	1,650	2
3	19	PROFESSIONAL FEES	Management Fees	925,144	4	50,550		375,514	20,518	3
4	20	LICENSES, DUES, FEES	Management Fees	925,144	4	1,241		375,514	504	4
5	21	CLERICAL & GENERAL	Management Fees	925,144	4	333,861	242,217	375,514	135,513	5
6	22	EMPLOYEE BENEFITS	Management Fees	925,144	4	73,426		375,514	29,803	6
7	25	AUTO EXPENSE	Management Fees	925,144	4	26,398		375,514	10,715	7
8	26	INSURANCE	Management Fees	925,144	4	9,432		375,514	3,828	8
9	30	DEPRECIATION	Management Fees	925,144	4	39,788		375,514	16,150	9
10	32	INTEREST	Management Fees	925,144	4	9,531		375,514	3,869	10
11	33	REAL ESTATE TAX	Management Fees	925,144	4	21,116		375,514	8,571	11
12	35	EQUIPMENT RENTAL	Management Fees	925,144	4	14,237		375,514	5,779	12
13	17	ADMINISTRATIVE	Direct Allocation			194,600			89,190	13
14	21	CLERICAL & GENERAL	Direct Allocation			42,969	42,969		21,484	14
15	22	EMPLOYEE BENEFITS	Direct Allocation			3,413			1,707	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 833,054	$ 285,186		$ 352,702	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salary Ron Shabat	Avge. Hrs Wkd	55	3	$ 250,000	$ 250,000	30	$ 136,364	1
2	17	Payroll Taxes	Avge. Hrs Wkd	55	3	8,459		30	4,614	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 258,459	$ 250,000		$ 140,978	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENT # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Canada Life Insurance		X	Mortgage	$26,142.00	10/31/86	$ 2,300,000	$ 272,352	11/01/01	11.0000	$ 43,713	1
2	Minolta Copier		x	Equipment Purchase		01/2000	21,285	12,485	02/05/02	18.3620	3,041	2
3												3
4												4
5												5
	Working Capital											
6	Success National Bank		X	Line of Credit				393,477		Various	78,225	6
7	Insurance Financing		x								1,460	7
8												8
9	TOTAL Facility Related				$26,142.00		$ 2,321,285	$ 678,314			$ 126,439	9
	B. Non-Facility Related*											
10	Supplemental Schedule										3,869	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,869	14
15	TOTALS (line 9+line14)						$ 2,321,285	$ 678,314			$ 130,308	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation from Future Assoc	X					$	$			$ 3,869	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 3,869	21

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	300,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	239,094	2
3. Under or (over) accrual (line 2 minus line 1).	$	(60,906)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	275,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	4,980	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	219,074	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	282,432	8
	1996	289,381	9
	1997	286,611	10
	1998	291,699	11
	1999	230,523	12
Estimate Allocation from Future		8,571	
Real Estate Tax Bill		230,523	
Total		239,094	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,900 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1986	$ 283,071	1
2					2
3	TOTALS			$ 283,071	3

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		1986		$ 2,548,850	$ 107,052	35	$ 72,824	$ (34,228)	$ 1,025,606	4
5			1986	Alloc from LCF	88,217	3,705	30	2,941	(764)	41,413	5
6			1987	Alloc from LCF	2,116	67	31.5	67		908	6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		20			4,800	9
10	Various			1981	57,728		20			57,679	10
11	Various			1982	11,967		20			11,967	11
12	Various			1983	3,440		20			3,440	12
13	Various			1984	12,700		20			12,388	13
14	Various			1985	98,707		20	1,477	1,477	93,415	14
15	Various			1986	42,087	239	20	2,214	1,975	32,240	15
16	Various			1987	17,729	563	20	563		7,879	16
17	Various			1988	35,577	1,129	20	1,129		14,160	17
18	Various			1989	14,591	463	20	463		5,363	18
19	Various			1990	27,693	879	20	879		9,303	19
20	Various			1991	62,352	1,980	20	3,118	1,138	28,874	20
21	Various			1992	10,152	322	20	508	186	4,572	21
22	Various			1993	21,815	247	20	1,092	845	8,308	22
23	Various			1994	264,384	5,874	20	13,222	7,348	82,774	23
24											24
25											25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				80,337	2,240		2,767	527	30,410	30
31	PAGE 12E TOTALS				69,787	663		1,435	772	1,435	31
32	PAGE 12D TOTALS				124,437	1,638		3,453	1,815	3,453	32
33	PAGE 12C TOTALS				77,306	1,983		3,866	1,883	5,917	33
34	PAGE 12B TOTALS				69,213	1,774		3,464	1,690	8,379	34
35	PAGE 12A TOTALS				209,028	5,544		10,456	4,912	49,018	35
36	TOTAL (lines 4 thru 35)				$ 3,955,013	$ 136,362		$ 125,938	$ (10,424)	$ 1,543,701	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	110,992	2,958	20	5,550	2,592	30,285	9
10	ROOF			1996	4,172	107	20	209	102	1,028	10
11	NURSES CALL SYSTEM			1996	1,200	31	20	60	29	245	11
12	CCTV SYSTEM			1996	3,271	84	20	164	80	806	12
13	CCTV MONITOR			1996	1,085	28	20	54	26	265	13
14	ELEVATOR ELECTRIC			1996	2,735	70	20	137	67	662	14
15	SHOWER STALLS			1996	3,000	77	20	150	73	713	15
16	CENTRAL A/C			1996	7,044	181	20	352	171	1,584	16
17	CCTV SYSTEM-TIME CLK			1996	1,126	29	20	56	27	247	17
18	BATHROOM VALVES			1996	3,950	101	20	198	97	858	18
19	DOOR & RAILINGS			1996	1,850	47	20	93	46	380	19
20	FLUSH VALVES			1996	2,475	63	20	124	61	506	20
21	CUBICLE TRACK			1996	553	14	20	28	14	138	21
22	FENCE			1996	1,675	116	20	84	(32)	357	22
23	ELECTRICAL LINE			1996	950	24	20	48	24	232	23
24	BOILER			1997	3,846	99	20	192	93	672	24
25	DOORS			1997	35,052	899	20	1,753	854	5,843	25
26	ROOF IMPROVEMT			1997	3,320	85	20	166	81	636	26
27	DOOR			1997	1,577	40	20	79	39	303	27
28	MISC IMPROVEMENTS			1997	2,700	69	20	135	66	484	28
29	VALVES			1997	2,300	59	20	115	56	393	29
30	ROOF IMPROVEMT			1997	4,340	111	20	217	106	723	30
31	TOILETS & VALVES			1997	1,250	32	20	63	31	205	31
32	DOORS			1997	2,090	54	20	105	51	341	32
33	DOORS			1997	975	25	20	49	24	155	33
34	JACUZZI			1997	2,500	64	20	125	61	469	34
35	ELEVATOR IMPROV			1997	3,000	77	20	150	73	488	35
36	TOTAL (lines 4 thru 35)				$ 209,028	$ 5,544		$ 10,456	$ 4,912	$ 49,018	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Solid core door			1998	710	18	20	36	18	78	9
10	Steel access panels			1998	2,881	74	20	144	70	384	10
11	Smoke Dampers			1998	4,875	125	20	244	119	732	11
12	Door completion			1998	5,901	151	20	295	144	885	12
13	Hot water pump & Exh			1998	2,430	62	20	122	60	264	13
14	Electrical Labor			1998	5,003	128	20	250	122	667	14
15	Roof Installation			1998	1,120	29	20	56	27	126	15
16	Seamless Gutters			1998	1,450	37	20	73	36	158	16
17	New doors			1998	8,495	218	20	425	207	1,275	17
18	Downspouts			1998	1,510	39	20	76	37	158	18
19	Double sliding door			1998	725	19	20	36	17	102	19
20	Roof North section			1998	660	17	20	33	16	96	20
21	Drywall and railings			1998	2,800	72	20	140	68	397	21
22	Bldg Renovaion			1998	1,383	35	20	69	34	201	22
23	Door locks			1998	6,655	171	20	333	162	916	23
24	Tuckpoint east wall			1998	3,100	79	20	155	76	323	24
25	ARCHITECT-REMODEL			1999	1,700	44	20	85	41	142	25
26	THRESHOLD KITCHEN			1999	1,433	37	20	72	35	120	26
27	KITCHEN IMPROVEMENTS			1999	3,037	78	20	152	74	241	27
28	WALLPAPER			1999	1,535	39	20	77	38	148	28
29	NEW PIPE - HEATER			1999	249	6	20	12	6	20	29
30	KITCHEN EXHAUST			1999	999	26	20	50	24	83	30
31	FRONT DOORS-THRESHLD			1999	1,421	36	20	71	35	112	31
32	WALLPAPER			1999	1,475	38	20	74	36	142	32
33	KITCHEN EXHAUST			1999	511	13	20	26	13	41	33
34	NEW SOLENOID KIT			1999	390	10	20	20	10	33	34
35	NEW DOORS			1999	6,765	173	20	338	165	535	35
36	TOTAL (lines 4 thru 35)				$ 69,213	$ 1,774		$ 3,464	$ 1,690	$ 8,379	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIRS			1999	5,240	134	20	262	128	415	9
10	Circular Pump			1999	4,738	121	20	237	116	474	10
11	EJECTOR PUMP			1999	5,571	143	20	279	136	465	11
12	ROD OUT SEWER			1999	625	16	20	31	15	44	12
13	CUBICLE CURTAINS			1999	1,237	32	20	62	30	83	13
14	220V FOR FREEZER			1999	500	13	20	25	12	50	14
15	TANK PATCH			1999	1,167	30	20	58	28	73	15
16	WALL AIR COND			1999	2,962	76	20	148	72	222	16
17	SEWER WORK			1999	3,395	87	20	170	83	241	17
18	EXIT DOOR ALARM			1999	700	18	20	35	17	50	18
19	WINDOW WELL COVERS			1999	1,646	42	20	82	40	109	19
20	KITCHEN FAUCETS			1999	1,081	28	20	54	26	72	20
21	FRONT CANOPY			1999	2,350	60	20	118	58	148	21
22	HINGES,HANGER, ETC			1999	1,697	44	20	85	41	128	22
23	CUBICLE CURTAINS			1999	1,261	32	20	63	31	100	23
24	ELECTRIC UPGRADE			1999	5,350	137	20	268	131	424	24
25	NEW SINKS			1999	2,500	64	20	125	61	198	25
26	WALL AIR COND			1999	2,344	60	20	117	57	176	26
27	ELECTRIC OUTLETS			1999	1,710	44	20	86	42	100	27
28	Door hinges			1999	1,402	36	20	70	34	134	28
29	FAUCETS			1999	1,941	50	20	97	47	178	29
30	CORNICES			1999	20,381	523	20	1,019	496	1,444	30
31	PULL HANDLE DOORS			1999	1,014	26	20	51	25	60	31
32	WALL AIR CONDI.			1999	3,586	92	20	179	87	283	32
33	OUTLETS, WIRING			1999	733	19	20	37	18	74	33
34	FIRE ALARM PANELS			1999	1,408	36	20	70	34	128	34
35	KITCHEN & IAB FAUCTS			1999	767	20	20	38	18	44	35
36	TOTAL (lines 4 thru 35)				$ 77,306	$ 1,983		$ 3,866	$ 1,883	$ 5,917	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire suppression sys			2000	2,058	38	20	77	39	77	9
10	A/C thermostadt			2000	4,604	84	20	173	89	173	10
11	Door closers			2000	1,435	17	20	36	19	36	11
12	Air conditioneers			2000	4,311	42	20	90	48	90	12
13	Dual pres. control			2000	703	17	20	35	18	35	13
14	Rehung Door closers			2000	1,183	29	20	59	30	59	14
15	3 grease traps			2000	7,345	149	20	306	157	306	15
16	1 htgValves"			2000	556	12	20	26	14	26	16
17	Air conditioneers			2000	3,646	58	20	121	63	121	17
18	Rebult lift assemb			2000	557	4	20	9	5	9	18
19	Repair rehang door			2000	1,578	28	20	59	31	59	19
20	SS Panel			2000	372	5	20	11	6	11	20
21	Install door frames			2000	4,150	31	20	69	38	69	21
22	Vinyl floor tile			2000	566	6	20	12	6	12	22
23	New elect pipe wire			2000	1,300	12	20	27	15	27	23
24	New Ceiling, Fixture			2000	6,205	73	20	155	82	155	24
25	Replace shower fauct			2000	2,800	15	20	35	20	35	25
26	Repair A/C lines			2000	2,804	27	20	58	31	58	26
27	New gas line			2000	875	12	20	26	14	26	27
28	Repair doors			2000	2,184	30	20	64	34	64	28
29	Enviormnt testing			2000	1,445	32	20	66	34	66	29
30	Flooring, Wallcover			2000	63,063	876	20	1,839	963	1,839	30
31	Det Heat 194F			2000	1,121	28	20	56	28	56	31
32	Borders resident rm			2000	637	1	20	3	2	3	32
33	Borders Resident rm			2000	7,600	8	20	32	24	32	33
34	Probes for tank			2000	567	1	20	2	1	2	34
35	Kitchen exhaust fan			2000	772	3	20	7	4	7	35
36	TOTAL (lines 4 thru 35)				$ 124,437	$ 1,638		$ 3,453	$ 1,815	$ 3,453	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door closures			2000	1,213	4	20	10	6	10	9
10	Repair oven doors			2000	691	14	20	29	15	29	10
11	Valves,ovrhd pipe			2000	1,997	40	20	83	43	83	11
12	Templer sprink.syst			2000	1,609	15	20	33	18	33	12
13	Wall - Employee DR			2000	2,411	8	20	20	12	20	13
14	Ceiling Dining room			2000	20,041	150	20	334	184	334	14
15	Lobby baseboard			2000	1,437	8	20	18	10	18	15
16	New ceilings			2000	16,027	86	20	200	114	200	16
17	Repair dining door			2000	481	4	20	8	4	8	17
18	Door Hldr, Ball bear			2000	1,130	23	20	48	25	48	18
19	Light fixtures			2000	22,067	307	20	643	336	643	19
20	Wallpaper			2000	683	4	20	9	5	9	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 69,787	$ 663		$ 1,435	$ 772	$ 1,435	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from LCF			1987	12,141	386	32	386		5,107	9
10	Allocated from LCF			1988	682	22	32	22		267	10
11	Allocated from LCF			1989	254	8	32	8		91	11
12	Allocated from LCF			1993	7,052	181	39	181		1,332	12
13	Allocated from LCF			1994	10,754	276	39	276		1,779	13
14	Allocated from Future Assoc			1987	38,263	1,215	32	1,215		17,159	14
15	Allocated from Future Assoc			1994	11,191	152	39	679	527	4,675	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 80,337	$ 2,240		$ 2,767	$ 527	$ 30,410	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 491,974	$ 31,474	$ 47,877	$ 16,403		$ 278,063	37
38	Current Year Purchases	120,330	15,098	6,992	(8,106)		6,992	38
39	Fully Depreciated Assets	361,898	121	2,507	2,386		361,898	39
40								40
41	TOTALS	$ 974,202	$ 46,693	$ 57,376	$ 10,683		$ 646,953	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocation from Future Assoc			$ 59,274	$ 4,739	$ 6,679	$ 1,940		$ 29,064	42
43										43
44										44
45										45
46	TOTALS			$ 59,274	$ 4,739	$ 6,679	$ 1,940		$ 29,064	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,271,560	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 187,794	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 189,993	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 2,199	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,219,718	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

PETERSON PARK HEALTH CARE CENTER
0024463
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Peterson Park	422,928	27,461	42,008	14,547	229,960
Future Assoc	69,046	4,013	5,869	1,856	48,103
TOTALS	491,974	31,474	47,877	16,403	278,063
LINE 29: CURRENT YEAR					
Peterson Park	113,995	13,831	6,675	(7,156)	6,675
Future Assoc	6,335	1,267	317	(950)	317
TOTALS	120,330	15,098	6,992	(8,106)	6,992
LINE 30: FULLY DEPRECIATED					
Peterson Park	316,190		2,313	2,313	316,190
Future Assoc	45,708	121	194	73	45,708
TOTALS	361,898	121	2,507	2,386	361,898
TOTALS (Should Tie to Totals on Page 13)					
Peterson Park	853,113	41,292	50,996	9,704	552,825
Future Assoc	121,089	5,401	6,380	979	94,128
TOTALS	974,202	46,693	57,376	10,683	646,953

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 780 Description: Postage machine
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation From future assoc		$	$ 5,779	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,779	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 7,302	$		$ 7,302	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,616			12,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			51,984			51,984	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				52,039		52,039	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2;39-3				7,962	19,725		27,687	13
14	TOTAL			$		$ 79,864	$ 71,764		$ 151,628	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	12,696
5	Med Tube; Ent & Urol	7,029
6		
7		
8		
9		
10		
		19,725

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	2,223
2	Lab & X ray	5,739
3		
4		
5		
6		
7		
8		
9		
10		
		7,962

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 607	$	1
2	Cash-Patient Deposits	51,264		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	910,329		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,136		6
7	Other Prepaid Expenses	901		7
8	Accounts Receivable (owners or related parties)	210,967		8
9	Other(specify): See supplemental schedule	202,606		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,441,810	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	102,484		13
14	Buildings, at Historical Cost	2,548,850		14
15	Leasehold Improvements, at Historical Cos	1,076,954		15
16	Equipment, at Historical Cost	1,081,194		16
17	Accumulated Depreciation (book methods)	(3,226,577)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	4,695		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,587,600	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,029,410	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,320,774	$	26
27	Officer's Accounts Payable	43,836		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	393,477		29
30	Accrued Salaries Payable	440,887		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,374		31
32	Accrued Real Estate Taxes(Sch.IX-B)	275,000		32
33	Accrued Interest Payable	7,612		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,500,960	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	272,352		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	12,485		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 284,837	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,785,797	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 243,613	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,029,410	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER **#** 0024463 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow	175,521		Accrued Expenses		
Employee Advances	27,085		Accrued R. E. Tax - Non Care Property		
	202,606				
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
			Capitalized Lease	12,485	
Construction In Progress					
Utility Deposit					
Loan Costs	13,217				
Accumulated Amortizaion - Loan Costs	(9,330)				
Exchange	808				
	4,695			12,485	

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,092	1	
2	Restatements (describe):		2	
3	Schedule attached	(119,302)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (103,210)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	459,423	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(112,600)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 346,823	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 243,613	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	PETERSON PARK HEALTH CARE C#	0024463	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(103,210)
Adjustments:		
		-
		-
		-
Round off Adjustment		2
Allowance for Bad Debts		119,300
Total adjustments		119,302
Balance - Beginning of Year		16,092
Equity(Deficit) from Page 17 Col 1		243,613
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		243,613

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,910,242	1
2	Discounts and Allowances for all Levels	(260,588)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,649,654	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	202,420	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 202,420	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	45,628	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,365	20
21	Other Medical Services	96,155	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 150,148	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	367,827	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 367,827	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,370,049	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,072,708	31
32	Health Care	2,558,760	32
33	General Administration	1,515,268	33
	B. Capital Expense		
34	Ownership	509,050	34
	C. Ancillary Expense		
35	Special Cost Centers	151,628	35
36	Provider Participation Fee	103,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,910,626	40
41	**Income before Income Taxes (line 30 minus line 40)****	459,423	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 459,423	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PETERSON PARK HEALTH CARI # 0024463 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,310	2,486	$ 77,110	$ 31.02	1
2	Assistant Director of Nursing	2,008	2,206	66,518	30.15	2
3	Registered Nurses	33,542	37,384	782,352	20.93	3
4	Licensed Practical Nurses	6,490	7,839	152,134	19.41	4
5	Nurse Aides & Orderlies	91,299	106,254	889,006	8.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	17,774	19,160	163,128	8.51	10
11	Social Service Workers	16,875	19,434	220,427	11.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers	23,303	26,363	253,068	9.60	16
17	Maintenance Workers	3,932	4,469	53,258	11.92	17
18	Housekeepers	11,528	12,675	91,934	7.25	18
19	Laundry	8,187	9,115	73,695	8.09	19
20	Administrator	4,120	4,320	126,046	29.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,190	7,193	67,102	9.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,474	2,714	27,361	10.08	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	230,032	261,612	$ 3,043,139 *	$ 11.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	460	$ 17,235		35
36	Medical Director	Monthly	15,600		36
37	Medical Records Consultant				37
38	Nurse Consultant	433	24,219		38
39	Pharmacist Consultant	Monthly	3,864		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	204	12,448		41
42	Respiratory Therapy Consultant	5	158		42
43	Speech Therapy Consultant				43
44	Activity Consultant	770	3,878		44
45	Social Service Consultant	192	8,460		45
46	Other(specify) Religious	10	2,160		46
47	Rehab Consultant	4	95		47
48	Purchasing Consultant	96	3,666		48
49	TOTAL (lines 35 - 48)	2,174	$ 91,783		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLENE WELLS	Administrator		$ 85,921
RONALD SHABAT	Director	39%	40,125
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,046

B. Administrative - Other

Description	Amount
Future Associates	$ 375,514
TOTAL (agree to Schedule V, line 17, col. 3)	$ 375,514
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Acctg	$ 80,925
Success National Bank	Acctg	1,000
Personnel Planners	UC Consultant	1,120
DSMA	Marketing	15,000
Schwartz & Freeman	Legal	450
Sachnoff & Weaver	Legal	17,189
Martin Schultz	Legal	750
Pollack & Weiss	Legal	4,980
Adjust to G/L	Legal	(3,736)
Illinois Assoc of HC Facilities	Union Negotiation	188
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 117,866

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,550
Unemployment Compensation Insurance	24,091
FICA Taxes	232,536
Employee Health Insurance	48,977
Employee Meals	36,893
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,920
Health & Welfare Fund	55,131
Employee Life Insurance	21,229
Employee Education	6,877
Miscellaneous	196
Holiday Expense	7,648
Allocation from Future	31,510
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,558

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,913
Health Care Worker Background Check	
(Indicate # of checks performed 417)	4,232
Advertising	37,402
Illinois Council Long Term Care	7,755
Other Dues & Subscriptions	493
Licenses & Fees	2,882
Employee Recruitment	7,000
Allocation from Future	504
Less: Public Relations Expense	( )
Non-allowable advertising	(37,402)
Yellow page advertising	(436)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,670
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,670

**See instructions.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	5/97	$ 1,765	3	$ 392	$ 588	$ 588	$ 197	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,765		$ 392	$ 588	$ 588	$ 197	$	$	$	$	$

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council Long Term Care - 7755**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,555** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. **No**

(9) Are you presently operating under a sublease agreement? YES **XX** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **XX** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **103,212**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **36,893** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **No**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw